Nevada Health Insurance Exchange: Planning Considerations
July 2010

In recent health care reform planning meetings and conferences there has been repeated emphasis on the need to make early state decisions related to the Health Insurance Exchange. Currently, the Department's Health Care Reform Workgroup has been focused on creating the administrative mechanism for enrollment, particularly for individuals up to 400% of the Federal Poverty Level (FPL). However, it has become evident that we must make specific planning assumptions related to the Exchange.

This white paper presents important goals for the Health Insurance Exchange and presents issues and opportunities which emphasize the importance of early planning and decision making. It also seeks to ask key questions about the Exchange necessary to proceed with planning Nevada's eligibility systems and its relationship to the Exchange. This white paper sets forth a series of recommendations and assumptions in order to facilitate that planning.

Some of the information for this white paper was sourced from a recent presentation by Robert Carey of the Public Consulting Group, Focus on Health Care Report by the Kaiser Family Foundation, and a report by Linda Blumberg and Karen Pollitz of the Urban Institute (See reference at the end of this white paper).

Basic Role of the Exchange

The Patient Protection and Affordable Care Act (ACA) broadly identified goals for Health Insurance Exchanges. Exchange design is critical to assuring these goals are met. Those goals are as follows:

- Slowing medical inflation;
- Ending exclusionary practices such as denial of coverage for pre-existing conditions;
- Facilitating plan selection and enrollment;
- Determining and providing subsidies to low-income residents;
- Ensuring meaningful health coverage; and
- Promoting transparency and accountability with health plans and providers.

<u>Bending the Cost Curve</u>

The Exchange can attempt to lower the cost of health care by creating competition among plans, and also among providers of service. However, any savings will be highly dependent on policies established by the Exchange's governing body. The Exchange could facilitate competition by being granted authority to negotiate rates with plans, and establishing policies for excluding high-cost plans. This would be a new function as the Insurance Division does not negotiate rates with plans.

Exchange policies related to plan design can also facilitate consumer value decisions, including selection of lower cost plans, which in turn will increase price competition. Increased competition among plans and the concentration of covered lives in the Exchange could also increase provider competition on cost and quality. While standardizing benefits will help

consumers with price comparisons, it will have to be balanced with creative market offerings and choice.

Insurance divisions and Medicaid agencies do not have all the expertise needed to manage the Exchange and the dynamics of the market place. This suggests that a new state governance structure is necessary to oversee the Exchange. This will be discussed in more detail later in this document.

Spreading Risk

Currently, the health insurance market focuses on avoiding or segregating adverse risk, which leads to processes like medical underwriting and excluding coverage of pre-existing conditions. Spreading risk helps stabilize the cost of coverage and can help make coverage available at a reasonable cost when people are sick.

The concentration of covered lives is essential in spreading risk across a large population. The National Governor's Association recently estimated that states may be overseeing health insurance coverage for 25% to 50% of their state's residents through the Exchange. Utah officials reported that they anticipate 80% of their residents will enroll in coverage through their Exchange. Exchange policies on risk selection, including community rating requirements in the ACA, will be required to prevent segregating behaviors among health plans.

To create additional opportunities for risk spreading and avoiding risk segregation, consideration should be given to increasing the numbers of lives flowing through the Exchange. By January 1, 2014, each state must have an operational Exchange where residents may purchase insurance coverage from qualified health plans. States must also establish a Small Business Health Options Program (SHOP Exchange). This can be a separate Exchange or be a part of the main Exchange. In considering the advantage of "large numbers" in risk spreading, it may be necessary to include the SHOP Exchange in the overall statewide Exchange.

There is also a policy question as to whether a state creates the Exchange as an exclusive marketplace versus allowing coverage to be purchased outside of the Exchange. The ACA requires each carrier to pool risk for all non-grandfathered plans in the individual and small group markets. This provides some protection against risk selection outside of the Exchange. However, there is still the potential for this to occur. It will be important to monitor these markets to assure risk selection does not re-occur.

Facilitating Plan Enrollment

Making plan selection as easy and transparent as possible for small employers and individuals subject to the mandates in the ACA will be essential. Accurate and reliable information on benefits, premiums, subsidies and options will be a key Exchange function, as well as enrolling individuals in the correct plan after they make a plan choice.

Reducing the "churn" between Medicaid and qualified health plans in the Exchange will reduce state and health plan administrative costs and assure better continuity of care. To deal with this, some states are considering requiring Medicaid plans to also participate as a qualified health plan

in the Exchange. Currently, of the two contracted Medicaid HMOs in Nevada, only one has commercial lines of business as well as a Medicaid line of business.

Determining and Providing Health Insurance Subsidies

Calculating subsidies and assuring those subsidies are provided to the enrollee's chosen health plan will be an administrative challenge. To administer subsidies, the Exchange would need to gather and evaluate information relevant to an individual's ability to pay for insurance. Centralizing administration of subsidies and payments to insurers in the Exchange may provide an efficient means of managing these payments. Procedures and technology for enabling these functions will take time to design and implement.

Ensuring Meaningful Coverage

Health coverage should pay medical bills when someone is sick and accesses medical services. This can be promoted by requiring health plans to provide a minimum standard of coverage to qualify as an Exchange plan. Qualified health plans must offer "essential health benefits" commonly found in standard employer health policies. Benefit plans must fall into five categories based on actuarial value: Platinum; Gold; Silver; Bronze; and High Deductible Health Plans (HDHPs),[1] which will be limited to the Individual Exchange market. Plans must also meet requirements for provider choice, accreditation and other criteria. Enforcement of these plan requirements will be the responsibility of the Exchange in coordination with the Insurance Division..

However, there will be pressure to increase the level of benefits required of plans. There will also be pressure on qualified plans to meet administrative or quality requirements beyond the minimum required under the ACA. More benefits and more administrative requirements will obviously lead to greater cost. In addition, states may require plans offer benefits in addition to the minimum essential health benefits, but the State must make payments to individuals eligible for subsidies to offset the cost of these additional benefits.

Standard benefit plans will facilitate risk spreading in the Exchange as standard benefit plan designs will discourage consumers from gravitating to a particular plan design based solely on medical needs. Experience with Medicare Part D suggests this can be an issue. Patients with high cost prescription medications would "plan shop" to find the best deal for their particular medical condition causing them to aggregate in a particular plan that offered that drug. However, standard benefit design will have to be balanced with creative market offerings to assure that consumers have a choice of products.

Promoting Transparency and Accountability

Transparent information for consumers about plan provisions, such as premium costs, point-of-service cost sharing, and covered benefits, is essential. Additionally, comparative information on

[1] Catastrophic plans may only be purchased by individuals 30-years old or younger, or by people who are exempt from the individual mandate based on affordability or hardship.

plan performance related to consumer satisfaction, provider choice, managing disease and keeping administrative costs low will also be important for the Exchange to provide consumers. Transparency and disclosure of data will also be necessary to monitor regulatory compliance by plans, as well as assuring plans comply with rules to promote risk spreading.

Nevada's Proposed Eligibility Engine

The Division of Welfare and Supportive Services (DWSS) is currently working with the Public Consulting Group (PCG) on an evaluation of a proposed "Eligibility Engine." This system application is called the Individual Access Model. A schematic of the proposed "Engine" is attached.

The Engine is currently envisioned to reside in conjunction with but separate from the electronic portal through which residents will access the Individual Insurance Exchange. Eligibility determinations, based upon adjusted gross income levels, will direct residents seeking insurance coverage to:

- Unsubsidized plan options (incomes above 400% of the Federal Poverty Level (FPL))
- Subsidized plan options if income is below 400% of FPL.
- Medicaid coverage if income below 133% of FPL (plus 5% income disregard), or SSI.
- CHIP eligible children below 200% of FPL.

Additionally, it will:

- Calculate premium subsidies and credits available to individuals eligible for subsidized Exchange coverage. The evaluation will also consider how these subsidies will be provided to qualified health plans, and whether the Engine will perform this function.
- Provide an indication of possible eligibility for state administered public assistance programs providing information regarding application for these programs.

The design proposal is predicated on a number of key assumptions related to key policy considerations. These include:

- Nevada has not yet elect if the state will operate a Basic Health Program for individuals below 200% of the FPL (Section 1331 of the ACA). Consideration will be made for the possibility of future operation of a Basis Health Program
- Individual Exchange will be separate from the SHOP Exchange for the purpose of eligibility determination.
  Presumptive Eligibility options, other than what is currently offered, will not be implemented. However, starting January 1, 2014, hospitals may separately apply to CMS to do presumptive eligibility determinations irrespective of whether the state has exercised that option in their Medicaid state plan.

Attached are key design assumptions and a schematic which includes other key questions, some of which will be addressed through the initial evaluation of the proposed Eligibility Engine.

For planning purposes, the relationship between the Eligibility Engine and the Exchange is being defined as follows:

- The Engine is considered within the domain of responsibility of DWSS, until decisions are made otherwise to move it to another agency or under the Exchange authority.
- The Engine will only determine eligibility for the Individual Exchange and not the SHOP Exchange. Additionally, an interface between the SHOP Exchange and the Engine is not envisioned at this time. This assumption needs to be revisited in light of the fact that concentrating large numbers of enrollees in the Exchange is vital for risk spreading.
- The Engine will calculate subsidies and credits.

Key Decisions for the Exchange

How will the Exchange be Structured?

For planning purposes, it is assumed Nevada will operate its own Exchange. Consumers and employers may feel a greater sense of ownership if the Exchange represents their interests in their own state. Local accountability and oversight would be improved if the Exchange was established at a state level. Finally, negotiations with health plans may also be more effective if conducted on a local level.

Interstate exchanges will be allowed with approval of the Secretary. The ACA also requires the federal Office of Personnel Management to establish at least two multi-state qualified health plans that will operate in exchanges in each state. In addition, the Secretary along with the National Association of Insurance Commissioners will establish rules for "health care choice compacts" by July 2013. Beginning in 2016, states will be required to pass authorizing legislation to establish these compacts.

Combining the SHOP Exchange as a part of the larger Exchange must be considered for risk spreading. Additionally, offering employers and individuals similar products could reduce the "churn" affect on enrollment.

Recommendation: Establish a state-wide exchange combining the SHOP Exchange and Individual Exchange only for the purposes of risk pooling, not for eligibility purposes. . Future consideration may be given to participate in regional or multi-state exchanges once the rules for multi-state compacts are promulgated.

How Should the Exchange be Governed?

The Secretary of Health and Human Services must issue regulations governing the establishment and operation of Exchanges "as soon as practicable." States will be evaluated by the Secretary by January 1, 2013 to determine if they have taken adequate steps necessary to establish an Exchange that will meet federal requirements. If a state is deemed not ready, the Secretary will establish an Exchange within the State.

Key policy decisions will need to be made related to rating and plan requirements by the state many months in advance of the January 1, 2013 readiness date to allow insurance carriers sufficient time to evaluate their interest in participating in the Exchange.

To accomplish this in the short timeframe available, Nevada must establish an Exchange with the ability to:

- Establish policies and regulations;
- Assure compliance with federal and state laws and regulations;
- Negotiate premiums and coverage with qualified health plans; and
- Oversee and administer all of the functions fundamental to achieving the goals of the Exchange.

The most important role of the Exchange will be to act as a health care purchaser, or perhaps as a selective contractor, for a large portion of Nevada's residents and small businesses. While the state Medicaid agency and the Public Employee Benefit Plan function in this capacity today, these state agencies may not have breadth and depth of experience to deal with a much larger health insurance market that the Exchange will represent.

The Exchange should be established in state law. To assure it can act in time for successful implementation, the Exchange will need an appropriate level of authority to perform its functions across multiple agencies, including Medicaid/CHIP, the Public Employees Benefit Plan (PEBP) and the Insurance Division.

Another key issue is whether the Exchange will operates primarily as a purchaser for small business and consumers (with representation of consumers and employers on its board); or whether it acts more broadly as a market facilitator, potentially with health plans and providers on its board as well.

Under the ACA, the Exchange must be a state agency or non-profit entity established by the state. Functions of the Exchange may be subcontracted to an "eligible entity." An eligible entity may be the state Medicaid agency or other entity incorporated in the state, not affiliated with the insurance industry, but with experience in the small group and individual insurance markets.

Federal guidance will ultimately define what the role of the state may be to operate the Exchange. Nonetheless, several organizational models should be considered for the Exchange. The Exchange could either be established as: a state agency; a quasi-governmental entity; or an independent non-profit entity established by the State. In each case, this entity would need to have authority to establish regulations to carry out its purchasing mission.

It is important for the Exchange to have broad regulatory authority across multiple state health programs as well as the insurance industry. Governance of the Exchange needs to include the Insurance Division, Medicaid/CHIP, and the Public Employees Benefit Plan. Future consideration should also be given to include the Health Division as a part of the governance structure for the Exchange in order to facilitate its public health mission through data sharing and policy development.

While the actual structure of the Exchange is yet to be determined, it must have authority to act as the state's largest purchaser. If the decision is to not establish a separate Exchange with authority over other agencies, there will be at a minimum the need for significant coordination and cooperation between the Exchange, the Insurance Division, Medicaid and PEBP.

Recommendation: Establish a governance structure for the Exchange to include the Insurance Division, Medicaid/CHIP and PEBP.

How Should the Eligibility Engine be Governed?

With the creation of the Eligibility Engine, a multi-department governance structure will need to be developed in order to provide the framework for making IT decisions and to ensure that IT organizational resources are targeted to deliver maximum business value. The IT Governance process should answer the following questions:

- How will executive direction for IT be established?
- How will standards, policies and procedures be established and enforced?
- How will decisions be made regarding department-specific and enterprise-wide initiatives (e.g., business applications)?
- How will IT initiatives be prioritized? How will IT initiatives be funded?
- How will projects be governed? Who will be responsible for projects?

Recommendation: Creating a governance structure will provide a guide as to how individuals and groups will collaborate to manage technology and help to define the basis for interaction between functions, roles, programs and people as they relate to the technology that is necessary to support the implementation of Healthcare Reform.

Who Should Have Access to the Exchange?

The Exchange could be the exclusive market for small employers and individuals to get health care coverage. An alternative is to allow alternative markets to operate for either employers, individuals or both. The existence of alternative markets creates the potential for risk segregation. This risk will be reduced with the reinsurance and risk adjustment provisions of the ACA as well as the requirement for non-grandfathered plans to follow the same rating rules. This issue could also be addressed through state regulation of plans sold inside and outside of the Exchange.

Recommendation: Allow alternative markets to exist assuming they follow the rules established for qualified health plans in the Exchange. An analysis of the impact of alternative markets on risk selection to the Exchange may be needed to determine whether alternative markets should continue.

How Much Authority Should the Exchange Have Over Purchasing?

The Exchange could exist as a somewhat passive entity that accepts any plan that meets the requirements of a qualified health plan. An alternative would be for the Exchange to have

significant authority to negotiate with plans and limit participation of plans based on cost, quality and other factors. In order to have an effect on cost, the Exchange would have to assert its role as an active purchaser. The impact of the Exchange as a purchaser will have an increased importance depending on the share of the market it regulates. In this case, decisions to exclude a particular plan could be a strong motivator for plans to improve quality and reduce cost. Assuming alternative markets continue to exist, decisions by the Exchange could also affect these markets.

Recommendation: Allow the Exchange sufficient authority to achieve its goals as an active purchaser for small businesses and consumers. An alternative is to establish the Exchange as a selective contracting agent that only offers plans that meet quality and cost standards established by the Exchange.

This report uses information from the following documents:

1. "Federal Health Reform: The role of the Exchange and Lessons from Massachusetts," presentation to Academy Health Research Meeting by Bob Carey, Senior Advisor, PCG, June 29, 2010.
2. "Explaining Health Care Reform: What Are Health Insurance Exchanges?" FOCUS on Health Reform, Kaiser Family Foundation, May 2009.
3. "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals," Linda Blumberg and Karen Pollitz, Urban Institute, April 2009.